

Dresden Nuclear Power Station

6500 North Dresden Road Morris, IL 60450 815 942 2920 Telephone www.exeloncorp.com

10 CFR 50.73

SVPLTR # 14-0033

May 27, 2014

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, DC 20555-0001

Dresden Nuclear Power Station, Units 2 and 3

Renewed Facility Operating License Nos. DPR-19 and DPR-25

NRC Docket Nos. 50-237 and 50-249

Subject:

Licensee Event Report 237/2014-001-00, Secondary Containment Inoperable

Due to Two Interlock Doors Being Open Simultaneously

Enclosed is Licensee Event Report 237/2014-001-00, "Secondary Containment Inoperable Due to Two Interlock Doors Being Open Simultaneously." This report describes an event which is being reported in accordance with 10 CFR 50.73(a)(2)(v)(C), any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to control the release of radioactive material.

There are no regulatory commitments contained in this submittal.

Should you have any questions concerning this letter, please contact Mr. Glen Morrow at (815) 416-2800.

Respectfully,

Shane M. Marik Site Vice President

Dresden Nuclear Power Station

Enclosure: Licensee Event Report 237/2014-001-00

cc: Regional Administrator – NRC Region III

NRC Senior Resident Inspector - Dresden Nuclear Power Station

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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISS			SIC	ON APPR	APPROVED BY OMB: NO. 3150-0104 EXPIRES: 01/31/201							01/31/2017							
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SUBMISSION

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

YES (If yes, complete 15, EXPECTED SUBMISSION DATE)

On March 27, 2014, two secondary containment interlock doors were opened simultaneously. At approximately the same time, an Electrical Maintenance Department (EMD) First Line Supervisor (FLS) approached the interlock from the emergency diesel generator side of the 2/3-5850-137 door and two Equipment Operators (EO) approached the interlock from the Reactor Building (RB) side of the 2/3-5850-59 door. When both work groups proceeded to enter the interlock, it was realized the doors were open simultaneously and they immediately secured both doors in the closed position.

DATE

An apparent cause was not identified, however, the most probable cause was determined to be a failure of the magnetic vane operated limit switch on the 2/3-5850-59 EDG door. This determination was based off of historical poor performance of the component. As a result, the station is completing a modification to the interlock doors and replacing the existing limit switches.

Based upon the short duration of the secondary containment doors being opened simultaneously and that the Secondary Containment differential pressure remained negative during the course of this event, this event is of low safety significance. The station has adjusted the limit switch and is in the process of implementing a design modification.

An Engineering Evaluation was performed (per NEI 99-02, Regulatory Assessment Performance Indicator Guideline) to show this event did not constitute a Safety System Functional Failure.

02-2014)

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME	2. DOCKET	•	6. LER NUMBER	3. PAGE			
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Dresden Nuclear Power Station, Unit 2	05000237	2014	- 001 -	00		OF	ა

NARRATIVE

PLANT AND SYSTEM IDENTIFICATION

Dresden Nuclear Power Station (DNPS), Units 2 and 3, are a General Electric Company Boiling Water Reactor with a licensed maximum power level of 2957 megawatts thermal. The Energy Industry Identification System codes used in the text are identified as [XX].

A. <u>Plant Conditions Prior to Event:</u>

Unit: 02

Event Date: 3-27-2014

Event Time: 0151 hours CDT

Reactor Mode: 1

Mode Name: Power Operation

Power Level: 100 percent

Unit: 03

Event Date: 3-27-2014

Event Time: 0151hours CDT

Reactor Mode: 1

Mode Name: Power Operation

Power Level: 100 percent

B. Description of Event:

On March 27, 2014, two secondary containment [NG] interlock doors [IMEC] were opened simultaneously. At approximately the same time, an Electrical Maintenance Department (EMD) First Line Supervisor (FLS) approached the interlock from the emergency diesel generator side of the 2/3-5850-137 door and two Equipment Operators (EO) approached the interlock from the Reactor Building (RB) side of the 2/3-5850-59 door. When both work groups proceeded to enter the interlock, it was realized the doors were open simultaneously and they immediately secured both doors in the closed position. At this time, control room operators received alarm "902-4 E-21 U2/3 DIESEL GEN INTLK DOORS INOP/BYP" as would be expected with both doors open simultaneously; the alarm cleared when the doors were secured. The work groups communicated the failure to the Operations unit supervisors and were given instructions to exit through the RB door 2/3-5850-59 without further incident.

The event occurred during a period of elevated traffic through the interlock (i.e., while Diesel Generator work was in progress). To mitigate the potential for an additional failure following the event, the hand switches were administratively controlled and a door attendant was staged in the interlock to operate it. The attendant physically secured the opposite door when either door was opened. The doors were cycled approximately 300 times over the 24 hour period following the event; the interlock operated as expected.

An Engineering Evaluation was performed (per NEI 99-02, Regulatory Assessment Performance Indicator Guideline) to show this event did not constitute a Safety System Functional Failure.

C. Cause of Event:

Troubleshooting of the event was performed in accordance with station procedures, and no causal factors could be identified as a result of troubleshooting. Multiple scenarios were postulated but engineering did not identify any as an apparent cause of the event. However, the most probable cause was determined to be a failure of the magnetic vane operated limit switch on the 2/3-5850-59 EDG door. This determination was based off of historical poor performance of the component.

U.S. NUCLEAR REGULATORY COMMISSION (02-2014)

LICENSEE EVENT REPORT (LER) **CONTINUATION SHEET**

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Dresden Nuclear Power Station, Unit 2	05000237	2013	- 008 -	01	3	OF	3

NARRATIVE

D. **Safety Analysis:**

The time that both doors were simultaneously opened was about five seconds, which did not result in the reactor enclosure differential pressure dropping below the required vacuum of 0.25 inches water gauge. Both the inner and outer doors were closed by normal expected means and were capable of remaining closed as designed. Based on the short duration of both doors being opened simultaneously, and that there were no material conditions preventing door closure or maintaining the doors closed, the secondary containment safety function was maintained.

From a safety consideration, the primary purpose of the secondary containment is to minimize the ground level release of airborne radioactive materials and to provide a controlled, elevated release of the building atmosphere under accident conditions. Engineering Evaluation (EC) 397055 was performed to show that events of this nature have no impact on the safety function of secondary containment, given that no exfiltration from the reactor building would have occurred as result of the airlock door breaches. Therefore, the dose consequence from postulated releases from the reactor building during these short durations would be bounded by the existing design basis LOCA dose analysis. The safety significance of this event was minimal.

E. **Corrective Actions:**

The station is completing or has completed the following actions:

- 1. Complete installation of an interlock modification
- 2. Replace the magnetic limit switch on both the EDG and Reactor Building Doors

F. **Previous Occurrences:**

IR	Date	Sort Description
1493171	3/27/2013	Unit 2/3 Interlock Failure
1530208	6/28/2013	Unit 2/3 Interlock Failure
1562654	9/23/2013	Unit 2/3 Interlock Failure

G. **Component Failure Data:**

Manufacturer	Model	Туре
ZERO INTERNATIONAL	361A	Air Lock Doors